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PRINTED: 02/02/2017

FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES	$\wedge$	F
CENTERS FOR MEDICARE & MEDICAID SERVICES	 <u> </u>	<b>NOWB</b>

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			
	155149	B. WING		•	27/2011
		İ	TREET ADDRESS, CITY, STATE, ZIF 8181 HARCOURT ROAD INDIANAPOLIS, IN 46260	CODE	
(EACH DEFICIENT	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT	TON SHOULD BE THE APPROPRIATE	COMPLETION DATE
This visit was for a Licensure Silrvey. Investigation of Complaint IN 2008 deficiencies / elate Survey dates Jar Facility number: Provider number: AlM number: 10 Survey team: Connie Landinari Diena Zgonoran Christi Davids on R	a Recertification and State This visit included the omplaint IN00085048.  35048 substantlated, no ed to the allegations are cited.  nuary 24, 25, 26, 27, 2011  000070 155149 00266190  RN TC	F 000	Plan of correction in g This corrective action Does not constitute an Agreement by this fac Facts alleged or conclusion Forth in this statemen The plan of correction Corrective actions are	general, or in particular, admission or ility of the usions set at of deficiences. and specific prepared and/	
Medicare: 14 Medicald: 54 Other: 2 Total: 70 Sample: 5 This deficiency also accordance with 41	o reflects State findings in 10 IAC 16.2. pleted 1-31-11				
	PROVIDER OR SUPPLIEF  JRT TERRAGE REH  SUMM RYS  (EACH DET ICIENT REGULATORY OR  INITIAL COMMENT  This Visit was: for a Licensure Survey. Investigation of Co  Complaint IN 2008 deficiencies / elate  Survey dates Jar  Facility number: Alm number:	DENTIFICATION NUMBER:  155149  PROVIDER OR SUPPLIER  URT TERRACE REHABILITATION & HEALTH CARE C  SUMM RY STATEMENT OF DEFICIENCIES (EACH DIE! ICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL CONIMENTS  This visit wast for a Recertification and State Licensure Sit rvey. This visit included the Investigation of Complaint IN00085048.  Complaint IN 00085048 substantiated, no deficiencies / elated to the allegations are cited.  Survey dates January 24, 25, 26, 27, 2011  Facility number: 000070  Provider number: 155149  AlM number: 100266190  Survey team: Connie Landfran RN TC  Diena Zgonci RN  Christi Davids on RN  Courtney Harthilton RN  Densus bed tirpe: SNF: 8  SNF/NF: 63/: Total: 7(1)  Census payor type: Medicare: 14  Medicalo: 54  Other: 2  Total: 70  Sample: 5  This deficiency also reflects State findings in accordance with 410 IAC 16.2.  Quality review completed 1-31-11	IDENTIFICATION NUMBER:  155149  B. WING  PROVIDER OR SUI PLIER  JRT TERRACE REHABILITATION & HEALTH CARE CENT  SUMM LRY STATEMENT OF DEFICIENCIES (EACH DETICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This VISIT Wast for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00085048.  Complaint IN00085048 substantiated, no deficiencies / elated to the allegations are cited.  Survey dates January 24, 25, 26, 27, 2011  Facility number: 000070 Provider number: 155149 AIM number: 100266190  Survey team: Connie Landinan RN TC Diena Zgonei RN Christi Davids on RN Courtney Harhilton RN  Densus bed tirpe: SNF: 8 SNF/NF: 63! Total: 7(1)  Census payor type: Medicare: 14 Medicalo: 54 Other: 2 Total: 70  Sample: 15  This deficiency also reflects State findings in accordance with 410 IAC 16.2. Quality review, completed 1-31-11	This visit wat for a Recertification and State Licensure Stirvey. This visit included the Investigation of Complaint IN 00085048 substantiated, no deficiencies / elated to the allegations are cited.  Survey dates January 24, 25, 26, 27, 2011  Facility number: 100266190  Survey teams: Connie Landinan RN TC Diana ZgonoiRN  Census bed tirpe: SNF: 8  SNF/NF: 8  SNF/NF: 8  SNF/NF: 8  SNF/NF: 8  SNF/NF: 8  SNF/NF: 8  Complaint: 70  Census payof type: Medicare: 14  Medicare: 14  Medicare: 15  This deficiency also reflects State findings in accordance with 410 IAC 16.2.  Quality review completed 1-31-11	This visit wall for a Recertification and State Licensure Sel revey. This visit included the Investigation of Complaint IN 00085048.  Complaint IN 00085048 substantiated, no deficiencies felated to the allegations are cited.  Survey dates! January 24, 25, 26, 27, 2011  Facility number: 100266190  Survey leam: Connie Landfran RN TC Diena Zgone: RN Courtney Harl tilton RN Courtney Harl til

F 441 | 483.65 INFECTION CONTROL, PREVENT F
LABORATORY DIRECTOR'S OR FROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Imanstrator

TITLE

(XG) DATE

Any deficiency statement ending with an esterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey which her or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these old suments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

F 441

Event ID: YD0K11

Facility ID: 000070

FORM CMS-2567 (02-99) Previous Versions Obsolets

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PRINTED: 02/02/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTME	NT OF HI	EALTH	AND HUMAN	1 SERVICES
CENTERS F	OR MED	CARE.	& MEDICAID	SERVICES

STATEMEN AND PLAN	TOF DEFICIENCE	is	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE COMPI	
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			165140				.01/	C 27/2011
	PROVIDER OR SU		155149 ABILITATION & HEALTH CARE CE	NT	81	EET ADDRESS, CITY, STATE, ZIP CODE 181 HARCOURT ROAD IDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DE	ICIENO	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	SPREAD, I.I.  The facility in Infection Code safe, senitarity to help preve of disease at (a) Infection The facility in Program und (1) Investigation the facility (2) Decides in the facility (2) Decides in the facility (2) Decides in the facility (3) Maintains actions related (b) Preventing (1) When the determines of the facility communicated from direct occurrence (2) The facility communicated from direct occurrence (3) The facility hands after a hand washing professional (c) Linens Personnel mitotological professional contents of the facility of the facility hands after a hand washing professional contents of the facility of the facility hands after a hand washing professional contents of the facility of th	vense ventrol Franchister	stablish and maintain an Program designed to provide a comfortable environment and development and transmission ection.  Of Program stablish an Infection Control ich it - controls, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections.  Dead of Infection to of infection Program resident needs isolation to of infection, the facility must be the prohibit employees with a case or infected skin lesions with residents or their food, if the transmit the disease.  It require staff to wash their rect resident contact for which dicated by accepted	F	141	It is the intent of the facilia Nursing staff to utilize properly Hand washing prior to a Medication pass, and to a Scissors between resident F441 Infection control  1. Actions Taken:  A. In regards to Residents for Service for proper hand was infection control, appropriate of gloves, use of hand sanit appropriate cleaning of scissors/equipment prior to after each resident use.  2. Others Identified:  A. All residents could poter be affected.  3. Measures put in place:  A. All nursing staff in-service proper hand washing, infect control issues/concerns, usagioves and hand sanitizer, and appropriate cleaning of scissors/equipment prior to a after each resident use.	dean tuses.  # 44 and re-in- shing, to use izer, and  iced on ion ge of nd	

Facility ID: 000070

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

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FORM.	APPROVE(
MB NO.	0938-0391

DEPARTMENT OF HEALT	H AND HOWAN SERVICES
CENTERS FOR MEDICARI	
CENTERO I STUME DISTRICT	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

Ç

155149

B. WING

F 441

01/27/2011

NAME OF PROVIDER OR SUPPLIER

## HARCOURT TERRACE REHABILITATION & HEALTH CARE CENT

STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT ROAD INDIANAPOLIS, IN 46260

SUMN ARY STATEMENT OF DEFICIENCIES (EACH CE "ICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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## F 441 Continued From page 2

This REQUIREMENT is not met as evidenced

Based on observation, record review and interview, tall facility failed to ensure residents were free from the risk of infection from the lack of handwashing by staff, prior to medication pass and failed to clean scissors between resident use during one of two medication pass observations. This practice had the potential to affect 43 of 70 residents culrently in the facility. (QMA #1, LPN #2, Residents #44, #56)

Findings Include:

A policy dated 01/01/05 titled "Policy: Enteral Medication Administration" provided by the administratol on 01/26/11, at 8:15 A.M. included, but was not I mited to,..."1. Wash hands, don, glovės...."

A policy date 1 01/07 titled "Handwashing" provided by the administrator on 01/25/11, at 8:00 A.M., included, but was not limited to, "Policy: All staff will use croper handwashing technique to prevent the scread of infection as per Center of Disease Control Guidelines (Guideline for Infection Control in Hospital Personnel)...3. Repeat with each resident contact...."

On 01/24/11 at 1:40 P.M., during the medication pass observation on the B wing with 43 residents, LPN #2 dld not wash hands or use hand sanitizer before prepaling Resident #44 medications to be administered through a feeding tube (G-tube). No hand san izer was observed on the medication wirt. LPN #2 did not wash hands upon entering the room of Resident #44. LPN #2 did not don gloves prior to medication administration of Resident #44. LPN #2 stopped

- B. Proficiency for hand washing will be completed for all nursing staff.
- C. OMA's and Nurses' will have proficiency completed for proper hand washing and glove usage, and appropriate use of hand sanitizer.

## 4. How Monitored:

- A. DON/Designee will do random audits of three medication passes per week for 4 weeks and then monthly thereafter On going for proficiency.
- B. Administrator/Designee will review all audits as completed.
- C. All audits and proficiencies will be reviewed in the monthly QA&A meeting for review and Follow up.
- 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is February 14, 2011.

2-14-11

, DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 02/02/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING С B. WING 01/27/2011 155149 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUIPLIER 8181 HARCOURT ROAD HARCOURT TERRACE REHABILITATION & HEALTH CARE CENT INDIANAPOLIS, IN 46260 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION SUMM ARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DE ICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 441 F 441 Continued <sup>□</sup> om page 3 the continuous feedings and capped the end of the feeding tube. LPN #2 checked placement with auscultation. The LPN checked residual. She flushed the G-tube. LPN #2 administered the first medication through the G-tube. She flushed the G-tube. The LPN administered the second medication through the G-tube. She flushed the G-tube. LPN #2 administered the third medication. The LPN flushed the G-tube. She restarted the continuous feedings through the G-tube. At tl at time, LPN #2 was interviewed regarding the policy and procedure for maintaining infection control with medication pass. LPN it dicated she did not wash her hands prior to the riedication pass and that hand sanitizer was not on the medication cart. On 01/25/11 lat 9:00 A.M., during medication observation on the B wing with 43 residents, QMA #1 was observed retrieving scissors from the medication cart. The scissors were not cleaned before using hem to cut open four separate medication platches for Resident #56. After the medication was administered, QMA #1 put the scissors in hill scrub top pocket and exited the room. He then placed the scissors back in the med cart without cleaning off the scissors. QMA #1 was interviewed at that time, and indicated he was not award of any instructions or policy for cleaning the scissors between resident use. During the dally conference with the administrator and director of nursing on 01/26/11 at 3:00 P.M., a policy concerning cleaning soissors was requested. As of exit on 01/27/11, no policy or additional in dimation regarding the lack of a policy and procedure for cleaning the scissors between resident use was provided.

PRINTED: 02/02/2011

FORM APPROVED

DEPARTMENT OF HEALT	H AND HUMAN SERVICES
OFFICE COD METICAL	

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION: A. BUILDING C B. WING 01/27/2011 155149

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARCOURT TERRACE REHABILITATION & HEALTH CARE CENT			8181 HARCOURT ROAD INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMM ARY STATEMENT OF DEFICIENCIES  (EACH DETICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
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